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Using SNAPshot V3.83 to collect the version 1 AROC Ambulatory Clinical Dataset

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1 Purpose of this guide

This is a guide for clinicians and data entry workers using SNAPshot software to collect the AROC Version 3 Data Set.

1.1 More information

For information about how to use SNAPshot please refer to the user's guide, available on the SNAPshot 3.83 CD or download from the CHSD SNAPshot webpage and/or the user's guide specific to the AROC Ambulatory data collection, also on this CD and on the AROC website.

Detailed information on AROC and SNAPshot is available from:

- SNAPshot 3.8 User Manual. Centre for Health Service Development, University of Wollongong, 2007.
- SNAPshot web page - http://ahsri.uow.edu.au/chsd/snapshot/index.html
- AROC website - http://ahsri.uow.edu.au/aroc/index.html
- The AROC DataMatters newsletter, (available from the above website) contains occasional tips and feedback for SNAPshot users.

It is strongly recommended that SNAPshot users obtain some training prior to using SNAPshot to collect the version 1 AROC Ambulatory Clinical dataset.

1.1.1 What is SNAPshot?

SNAPshot is software designed primarily to collect “SNAP” (Sub-Acute and Non-Acute Patient) information. It has been used since 1996. SNAPshot has been modified for a range of applications including collecting the ACAT (ACAP), DVA, AROC, PCOC and HACC Minimum Data Sets.

SNAPshot has not been specifically designed to collect the AROC Data Sets. Information required for AROC is therefore entered into a number of different screens. Information relevant to AROC is then ‘mapped’ (or copied) into the AROC AmbulatoryDataset Screen. Some data fields can also be set to ‘default’ to the most common code or response for your facility to save time in data entry.

1.1.2 Logging on to SNAPshot

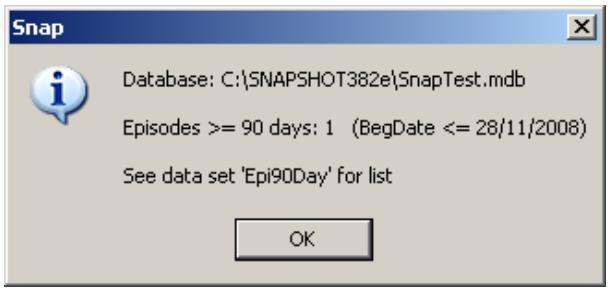
- Opening SNAPshot

  Double click on the SNAPshot shortcut on your desk top

  Shortcut to SNAPshot

  Or click Start, Programs, SNAPshot

- When SNAPshot opens, a pop-up will also open telling you how many Episodes have been open for 90 days or more. The location of your database file is also displayed. Click OK.

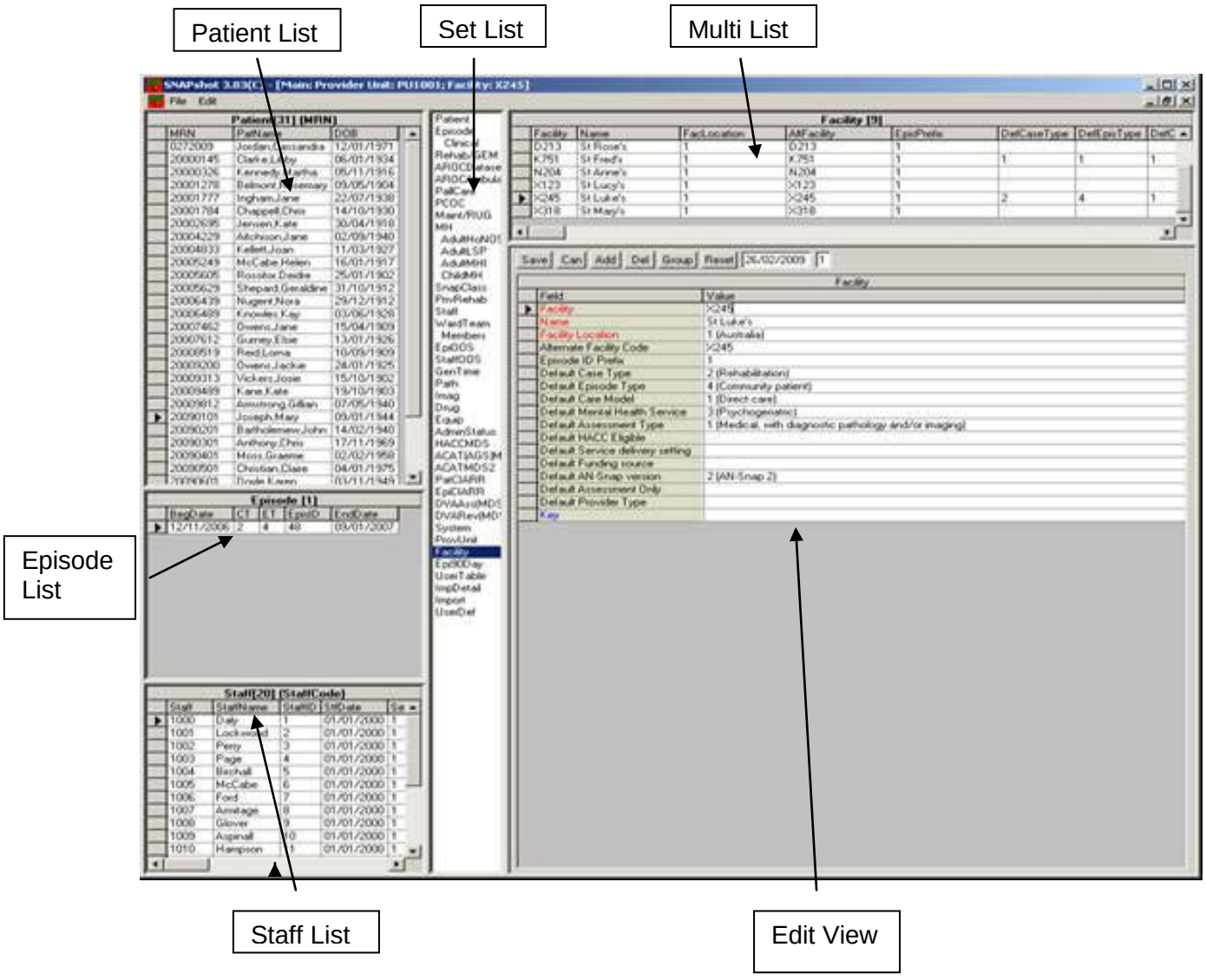


- Press Shift+F7 together. A pop-up will open asking you to enter the facility password to open the database.

1.1.3 The Main Screen

The Main Screen is where information is recorded about a facility, its staff, its clients' personal information and health status, and occasions of service provided.
The Main Screen has 6 parts: a Patient List, an Episode List, a Staff List, a Set List, a Multi List, and an Edit View.

Figure 1 SNAPshot main screen.



1.1.3.1 Moving Around the Main Screen

Point and click with the mouse to move to another field or another part of the screen.
Or use the following 'short-cut' keys:

- Use the F6 key to move from one part of the Main Screen to another.
- Use the Enter or Tab keys to move to the right or down to the next field. Use the Shift + Tab key to move to the left or up to the previous field.

See Appendix 1 for a complete list of 'short-cut' keys.

1.1.3.2 Different parts of the screen

Patient List

The "Patient List" displays the Name, Date of Birth and Medical Record Number (MRN) of the clients that have been registered by your facility.

Episode List

The "Episode List" shows each of the Episodes that have been opened for the client selected in the "Patient List". The Episode List displays the date the episode commence (BegDate), the Case Type (CT), the Episode Type (ET), the Episode Identifier (EpisID), and the date the episode ended (EndDate), if applicable.

Staff List

The "Staff List" shows the staff registered in your facility by Staff Number (Staff), Staff Name (StaffName), Staff Id (used internally by SNAPshot), Commencement Date (StfDate), and Session Type (Ses) which is used to identify either individual or group staff records.

Set List

The "Set List" shows all the different data sets contained within SNAPshot. The data set selected in the Set List is displayed in the Edit View window. Once selected, it is possible to make changes or additions to that data set.

Multi List

The "Multi List" contains various lists depending on the data set currently selected. For example, in ambulatory care settings, if the EpiOOS data set is selected the multi list will show the occasions of service entered for the client selected in the patient list.

Edit View

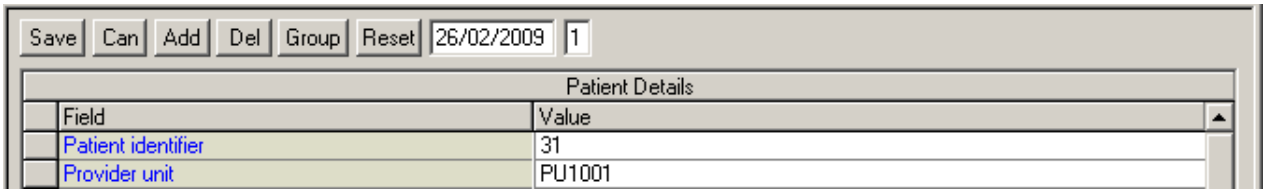
The "Edit View" is where information is added, deleted, edited or updated for the various data sets. If the patient data set is selected from the set list, then all of the fields for the patient data set are displayed in the edit view. This allows changes to be made to this data set.

1.1.4 Making changes or additions

The Edit View

The "Edit View" (refer to 1.1.3.2 above) is where information is added, deleted (with due care), edited or updated for the various data sets.

Figure 2 Transaction buttons at the top of the 'Edit View' screen.



Choose the data set that you want to make changes or additions to from the set list.
Click **Add** to create a new record in the data set.
Click **Save** to save a record that you have added or changed.
Before you can save a record you must move the cursor out of the field that you have changed by hitting the 'Enter' or 'Tab' key or by using the mouse to click in another field.
Click **Cancel** to cancel any changes that you have just made.
Click **Delete** if you want to delete a record from the data set.
A warning message will ask you if you are sure that you want to delete the record.
The **Reset** button is used to select a different Facility and Provider Unit, it may also be necessary to re-select the facility and provider unit after the database has been moved or restored.
The **Group** button is used to group the data into an appropriate SNAP class (refer to 3.2 below).

1.2 General Operations

The SetList segment lists all of the data sets that you can edit. When you click on a data set name – such as Patient or AROCAmbulatory – the fields for the data set are displayed in the EditView segment.

For some data sets – such as Facility – when you make the selection a list will appear in the MultiList segment and the currently selected facility record will appear in the EditView.

1.2.1 Transactions

As described above, all database transactions are performed in the EditView segment and include:

- **Add** – which is used to insert a new record of the type currently displayed in EditView.
- **Del** – which is used to delete the record currently displayed in EditView.
- **Save** – which is used to save the record currently displayed in EditView.
- **Cancel** – which is used to discard changes you have made to the record currently displayed in EditView.
- **Reset** – which is used to re-select all lists when you change provider unit or facility but which can also be used to refresh the data currently being displayed to reflect any changes made by other users.

When you are editing a data set the SetList will disappear and the message ***Edit*** will appear.

1.3 General Editing Controls

To edit an existing record in EditView, simply click on the relevant field and enter data. If you are moving from field to field, F2 can be used to put you into field edit mode. If there are multiple columns you can use Tab or Shift-Tab to move right and left or you can use the left and right arrow keys. To move up and down use the up/down arrow keys. Before you can press the Save button to save changes you must move off the field you have just edited (pressing the Enter key is fine) otherwise you will receive an error prompt.

Date formats are flexible – for example 01 Jan 2009 can be entered as 1/1/09 but it will be displayed as 01/01/2009. Note that separator character such as slashes or spaces must be entered. The current year will be assumed – eg '1 1' will convert to 01/07/2007.

1.3.1 Entering information into data fields

Many fields such as Impairment code have a drop down list with a code for each item. In these fields, you can either type the code directly into the field or make a selection from the drop down list. You can press **Alt + Down Arrow** together to open the drop down menu for the data field that you are in.

2 Entering client information

2.1 Client information for AROC Ambulatory is mainly entered into SNAPshot in 3 screens.

Figure 3 The "AROC" data sets in the set list

Initially at setup

- Facilty Screen
- Provider Unit

Screens primarily used for entering AROC data

- Patient screen
- Episode screen
- AROCAmbualtory

Most screens contain more data fields than those required by the AROC Ambulatory Clinical dataset. Non AROC dataset fields do not need to be completed for AROC reporting purposes.

Facilities may choose to complete additional items such as client names and telephone number for their own information or benefit. These fields will not be extracted or used by AROC.

As well as the AROC business rules, you will need to follow local business rules as to which data items need to be completed as your facility may be using the data collection for local reporting purposes or to satisfy other data collection needs (such as HACC, ACAP).

2.2 Default settings, mapped fields and 'Auto' responses

Some fields can have a default value set to the most common response within your facility. For example, Case Type can be set to default to Rehabilitation (2). This saves time when entering data and can be over-written if required. To set up or change your default settings go to the Facility Screen.

Many data items such as Mode of Episode Start are 'mapped' or copied from one Data Set to another. This minimises double data entry. Other data items such as the Episode Identifier are automatically generated. Mapped or automatically generated fields are coloured blue. They are 'read-only' and cannot be changed.

2.3 Initial setup: the 'facility' screen

The Facility Screen contains information to identify the facility, it is set up once, usually by the SNAPshot administrator at your site.

Table 1 Definitions for fields relevant to AROC in the 'Facility' Data Set

Snapshot field	AROC data item	Description
Facility code	Item 1	Enter a 4 character alphanumeric code for your facility. This would normally be the code issued by the Department of Health.
Facility name	Item 2	Enter the name of your establishment.

2.4 Initial setup: the 'provider unit' screen

The Provider Unit Screen contains information to identify the provider unit, it is set up once, usually by the SNAPshot administrator at your site. Typically there is a unique provider unit associated with each medical record system, in practice, this means that for each facility there will be one provider unit. This information is not collected by AROC but it is required by the SNAPshot software.

Table 2 Definitions for fields relevant to AROC in the 'Provider Unit' Data Set

Snapshot field	AROC data item	Description
Provider unit	Not collected	Enter a 6 character alphanumeric code for your provider unit, e.g. PU0001
Name	Not collected	Enter the name of your provider unit, e.g. Rehab

2.5 Initial setup: the 'wardteam' screen

The WardTeam Screen allows a site to set up a number of different programs or teams. Not all facilities will need or want to do this and completing these data items is not mandatory, but has been included in the AROC dataset to give those facilities that would like to be able to differentiate by program or team, the ability to do that.

When data relating to an episode is entered into SNAPshot, it can then be assigned to a specific ward/team (see Table 4, data items entered in the Episode screen)

Table 3 Definitions for fields relevant to AROC in the 'WardTeam' Data Set

Snapshot field	AROC data item	Description
Program identifier	Item 3	Enter up to a 4 character alphanumeric code for your ward or team, e.g. Tm01
Program Name	Item 4	Enter the name of your program/unit e.g. R.I.T.H

2.6 Entering information into the 'patient' screen

The Patient (Client) Screen contains identifying and demographic information.

Before adding a new patient/client, it is a good idea to check first to see if they are already in SNAPshot as this will avoid duplicate records. (Refer to Appendix 2 for how to search by MRN or Surname).

Adding a New Client (Patient) Record

1. Select the **'Patient'** data set from the **'Set List'**. The 'Patient Details' Screen will now be displayed in the 'Edit View'.
2. Click on **'Add'** — a new Client Record will be opened in the 'Edit View'.
3. Complete the fields as explained in Table 4 below.

Table 4 Definitions for fields relevant to AROC Ambulatory in the 'Patient' Data Set

Snapshot field	AROC data item	Description
Medical Record Number	Item 5	Client file number or medical record number (Maximum – 12 digits) – must be unique within Facility.
Date of Birth	Item 6	Client's birth date in format DD/MM/YYYY
Surname	Not collected	Helpful for local purposes, required for HCP
Given Names	Not collected	Helpful for local purposes, required for HCP
Sex	Item 7	Code for the patient's gender: 1. Male 2. Female 3. Indeterminate 9. Not stated/inadequately defined
Indigenous status	Item 8	Enter code for the patient's indigenous status. 1. Aboriginal but not Torres Strait Islander origin 2. Torres Strait Islander but not Aboriginal origin 3. Both Aboriginal and Torres Strait Islander origin 4. Neither Aboriginal nor Torres Strait Islander origin 9. Not stated / inadequately described
State	Item 9 (AUS only)	Enter the code for the state of residence. 1. New South Wales 2. Victoria 3. Queensland 4. South Australia 5. Western Australia 6. Tasmania 7. Northern Territory 8. Australian Capital Territory 9. Other Territories (Cocos Islands, Christmas Island, Jervis Bay Territory) 99. Other Country
Postcode	Item 10 (AUS only)	Enter the post code for the patient's usual address.
Country	Item 11*	Enter the code for the country of patient's residence (using the Standard Australian Classification of Countries (SACC))
DVA Number	Not collected	If episode is funded by DVA, then DVA card number is required for HCP
Type of usual accommodation prior to admission	Item 17*	Enter the code for the type of accommodation that the client lived in prior to hospitalisation for this admission. 1. Private residence (including unit in retirement village) 2. Residential aged care, low level care (hostel)

Snapshot field	AROC data item	Description
		3. Residential aged care, high level care (nursing home) 4. Community group home 5. Boarding house 6. Transitional living unit 7. Other
Funding source for hospital patient	Item 23*	Enter the code for the funding source for this episode. 1. Australia Health Care Agreements (public patient) 2. Private health insurance 3. Self-funded 4. Workers' compensation 5. Motor vehicle third party personal claim 6. Other compensation (eg public liability, common law, medical negligence) 7. Department of Veterans' Affairs 8. Department of Defence 9. Correctional facility 10. Other hospital or public authority (contracted care) 11. Reciprocal health care agreement (other countries) 12. Other 99. Not known
Health fund/other payer *(complete if 2, 4 or 5 entered in item 14)*	Item 24*	If you entered the value 2, 4, or 5 in item 23 you now need to specify the name of the funding organisation, enter the appropriate code from the drop down list – items are grouped by Health Fund, CTP Insurer, and Worker's compensation insurer.
Fund Membership number	Not collected	If Episode is funded by private health insurance then membership number is required by HCP.

** Update these fields in the episode screen if needing correction or if found missing when submitting to AROC.*

Once all information on the screen has been entered click **'Save'.**

2.7 Entering information into the 'episode' screen

An 'Episode of Care' is a sequence or period of care between a client ('Patient') and a facility.

An Episode begins:

- On admission to a facility (including change of case type)

An Episode ends:

- At discharge
- When the main goal of the care changes, that is, the 'case type' changes. For example if the main goal of care (case type) changes from Rehabilitation to Maintenance Care the Rehabilitation Episode should be closed and a new Maintenance Episode commenced.

The Episode Screen contains information specific to that episode of care, some of the information is mapped (copied) from the Patient screen.

Adding a new Episode Record

1. Highlight the required patient in the Patient List
2. Select the **'Episode'** data set from the **'Set List'**. The 'Episode Admin Details' Screen will now be displayed in the 'Edit View'
3. Click on **'Add'** — a new Episode Record will be opened in the 'Edit View'
4. Complete the fields as explained in Table 5 below.

Table 5 Definitions for fields relevant to AROC Ambulatory in the 'Episode' Data Set

Snapshot field	AROC data item	Description
Episode begin date	Item 19	Enter the date of the client's admission to an ambulatory rehabilitation program, in format DD/MM/YYYY.
Case type	Not collected	Enter the code for case type assigned on admission. For the AROC Ambulatory data collection this will always be 2 Rehabilitation and can be defaulted. ***The SNAPshot software requires this field to be completed to enable the record to be saved***
Episode type	Item 25	Enter the code for the client's episode type. Admission may be to a rehabilitation program in a centre based, outpatient or community-based setting. For the AROC Ambulatory data collection choose from options 2, 3 or 4 2. Same-day admitted patient. *Patient is admitted and discharged on the same date.* 3. Outpatient *Patient receives care in a hospital outpatient clinic.* 4. Community Patient *Patient receives care in the home or other non-hospital site.* ***The SNAPshot software requires this field to be completed to enable the record to be saved***
Assessment only	Item 12	If the client was seen on one occasion only for assessment and/ or treatment and no further intervention by this facility/ team is planned within the next 90 days, he / she is classified as "assessment only". Enter the code indicating whether the patient was seen for assessment only. 1. Yes. 2. No.
Mode of episode start	Item 20	R. Transferred from the emergency department S. Referred by General Practitioner T. Referred direct from Specialist rooms U. Referred by Therapist V. Transferred from Acute Inpatient Care, same hospital W. Transferred from Acute Inpatient Care, different hospital X. Transferred from Sub-Acute inpatient care, same hospital Y. Transferred from Sub-Acute inpatient care, different hospital Z. Other
Type of usual accommodation prior to admission	Item 17	***Can also be entered in patient screen – if previously entered maps to this screen*** Enter the code for the type of accommodation that the client lived in prior to a) any acute admission leading to this episode of ambulatory rehabilitation or b) any inpatient rehabilitation leading to this episode of ambulatory rehabilitation where there was no acute hospital admission or c) this ambulatory episode where there was no a) or b) 1 Private residence (including unit in retirement village) 2. Residential aged care, low level care (hostel) 3. Residential aged care, high level care (nursing home) 4. Community group home

Snapshot field	AROC data item	Description
		5. Boarding house 6. Transitional living unit 7. Other
Support provided prior to admission *(Required if response to item 17 was 1 – private residence)*	Item 18	Enter the code for the level of support that the client received prior to any admission (acute or sub-acute)leading to this episode of ambulatory rehabilitation: 1. Lives alone (no support/care provided) 2. Lives with others (no support/care provided) 3. Lives alone with external support(s) 4. Lives with others (who provide support/care) 5. Lives with others with external support(s) 6. Other arrangements 9. Not stated/inadequately described
Model of Care	Not collected	The type of care provided to the client. SNAPshot recognises 6 Models of Care as listed below. Typically for Rehabilitation patients this will be 1. Direct Care, and this can be defaulted. ***This item is a mandatory SNAPshot field, it must be completed to enable the record to be saved.*** *1 Direct care* *2.1 GP Shared care* *2.2 Shared care with another service provider* *3.1 GP Consultation/liaison* *3.2 Consultation/liaison with another service provider* *3.3 Consultation/liaison within the SNAP provider unit*
Episode end date	Item 29	Enter the date of discharge from rehabilitation in the format DD/MM/YYYY.
Mode of episode end	Item 30	A. Discharge/case closure. B. Died. C. Admitted to hospital as sub-acute/non-acute inpatient. D. Admitted to hospital as acute inpatient. E. Change of care type within sub-acute/non-acute care F. Change of episode type (between same-day admitted, outpatient and community) H. Discharged at own risk
Accommodation post discharge	Item 31	Enter the code for the type of accommodation that the client will be living in after discharge. 1. Private residence (inc unit in retirement village) 2. Residential aged care, low level care (hostel) 3. Residential aged care, high level care (nursing home) 4. Community group home 5. Boarding house 6. Transitional living unit 7. Other
Support provided at episode end *(Required if response to item 31 was 1 – private residence)*	Item 32	Enter the code for the level of support that the client received at episode end: 1. Lives alone (no support/care provided) 2. Lives with others (no support/care provided) 3. Lives alone with external support(s) 4. Lives with others (who provide support/care) 5. Lives with others with external support(s) 6. Other arrangements 9. Not stated/inadequately described
WardTeam	Items 3 & 4	Enter the code for the program or team (set up in Ward/Team screen) you wish to allocate to this episode.

Once all information on the screen has been entered click **'Save'.**

2.8 Entering information into the 'AROCAmbulatory' screen

Information about the client's ambulatory rehabilitation program of care is recorded in the AROCAmbulatory screen.

Adding a new AROCAmbulatory Record

1. Highlight the required patient in the Patient List
2. Select the **'AROCAmbulatory'** data set from the **'Set List'**. The 'AROC Ambulatory' data set details screen will now be displayed in the 'Edit View'
3. Click on **'Add'** — a new AROC Ambulatory Record will be opened in the 'Edit View'
4. Complete the fields as explained in Table 6 below.

Table 6 Definitions for fields in the 'AROCAmbulatory' screen.

Snapshot field	AROC data item	Description
Employment Status	Item 13	Enter the code for the patient's employment status (refer Appendix 5 for inclusions and exclusions by code). 1. Employed 2. Not Employed 3. Not in Labour Force 9. Not stated/inadequately described
Date of Onset	Item 14	Collect the date the impairment occurred that lead to this episode of ambulatory rehabilitation. (e.g. date of stroke, amputation, hip fracture, elective joint surgery) in the format DD/MM/YYYY
Time Since Onset *(this only needs to be collected if Item 14 'Date of Onset' is unknown or applicable)*	Item 15	Enter the code for the timeframe from when the reason for rehabilitation started affecting the patient's function (e.g. time since arthritis flare up) where the date of impairment is unkown or had an insidious onset) 1. Less than one month 2. 1 month to less than 3 months 3. 3 months to less than 6 months 4. 6 months to less than 1 year 5. 1 year to less than 2 years 6. 2 years to less than 5 years 7. 5 years or greater 9. unknown
First admission for this impairment	Item 16	Identify if this is the **first** rehabilitation admission for this impairment (previous rehabilitation programs may have been inpatient or ambulatory and may have been recently or some time ago) 1. Yes 2. No
Type of accommodation during episode	Item 21	Enter the code for the type of accommodation the patient will be living in during this episode of ambulatory rehabilitation. (Where accommodation is 'private residence' only answer Code 1. if the same address as for item 17 'usual accommodation'. For 'private residence' but different address to usual accommodation please specify reason for change using either Code 2. 3. or 4.) 1. Pre impairment accommodation *(same address as Item 17)* 2. Interim accommodation, due to geographical(access)

Snapshot field	AROC data item	Description
		issue *(may be private residence, hostel or nursing home)* 3. Interim accommodation, due to increased support required *(may be private residence, hostel or nursing home)* 4. Other
Level of support received during episode	Item 22	Enter the code for the level of support that the client received during this episode of ambulatory rehabilitation 1. Lives alone (no support/care) 2. Lives with others (no support/care) 3. Lives alone with external support/s 4. Lives with others (who provide support/care) 5. Lives with others (with external support) 6. Other arrangements 9. Not stated/inadequately described
Total number of days seen	Item 26	Enter the total number of days that service(s) were provided to the patient. For example , if the patient attended the rehab centre twice a week for 4 weeks the count would be 8
Total number of Occasions of service	Item 27	Enter the total number of occasions of service to the patient. For example, if the patient attended the rehab centre twice a week for 4 weeks , and had physiotherapy and hydrotherapy at each visit the total count would be 16
Staff type providing therapy	Item 28	Please indicate all the **therapies** that were provided to the patient during this episode of care, choose up to 10. **Note:** this item is designed to capture information about the type of therapy experienced by the patient during the episode, a single therapist may deliver more than one type of therapy e.g. physio and hydrotherapy done by the physiotherapist; in this instance record both physiotherapist and hydrotherapist in staff type.
AROC Impairment code	Item 33	Primary reason for admission to the rehab program. There are 16 groups of impairment codes (refer Table 2 and Table 3 – AROC Impairment Coding Guidelines)
Episode Start Lawton's score	Item 34	Enter the Australian Modified Lawton's Score on admission to ambulatory rehabilitation. 1. Telephone (range 1-4) 2. Shopping (range 1-4) 3. Food preparation (range 1-4) 4. Housekeeping (range 1-4) 5. Laundry (range 1-4) 6. Mode of transportation (range 1-4) 7. Responsibility for own medications (range 1-3) 8. Ability to handle finances (range 1-3)
Date Episode start Lawton's assessed	Item 35	Enter the date of assessment in format DD/MM/YYYY
Episode Finish Lawton's score	Item 36	Enter the Australian Modified Lawton's Score on discharge from ambulatory rehabilitation. 1. Telephone (range 1-4) 2. Shopping (range 1-4) 3. Food preparation (range 1-4) 4. Housekeeping (range 1-4) 5. Laundry (range 1-4) 6. Mode of transportation (range 1-4)

Snapshot field	AROC data item	Description
		7. Responsibility for own medications (range 1-3) 8. Ability to handle finances (range 1-3)
Date Episode finish Lawton's assessed	Item 37	Enter the date of assessment in format DD/MM/YYYY
Comment	optional	An optional comment relevant to this episode of care. Up to 50 characters can be entered, for example if the patient is unusually young or old you could note that the DOB had been confirmed.

Once all information on the screen has been entered click **'Save'**.

3 Data extraction and reporting

3.1 The Report Database and AROC Inpatient extract

To display the Snap Report dialog screen, press Shift-F8 whilst positioned on any of the data lists.

The Snap Report dialog screen provides the following controls:

1. The location and name of the report database.

2. The location and name of the folder into which extracts will be placed.

3. A list of reports – click on the report you wish to generate.

4. Selection criteria – enter the values you wish to use to select particular subsets of the database.

5. A page throw option which is enabled for some reports to allow you to specify that the data for each patient is to commence on a new page.

6. Operation buttons – Generate and Exit.

3.1.1 The Report Database

When you generate a report the data are written into an Access database which is different from the main database. Each user (PC) should have a separate report database – preferably on the local hard disk drive. If the report database has to be stored on a server computer, each user should have a different file. Typically this file is called RepDB.mdb and is located in C:\SNAPshot however you can change this.

When you change the report database name, Snap will either select an existing file or, if it does not exist, will create it for you.

3.1.2 The Report Database Folder

You can create as many report databases as you like – for example you might want to keep the tables which are generated during a session for analysis using another system. In this situation it is normally preferable to keep the report databases in the same folder. However, if you wish to use multiple folders you will have to copy the .rpt files into each folder where you store report databases.

The reporting facility inside Snap uses Crystal Reports version 8 and the .rpt files are the report definition files. You should not change the .rpt files if you have a copy of the Crystal Reports system installed.

3.1.3 Extract Folder

The default extract folder is C:\SNAPextract. You can use this default folder or you can specify another folder in which to write the data extract files. This folder can be on a different computer, for example, on a server.

If the folder you set for your extracts does not already exist, you will be asked if you want it to be created. You should answer 'Yes'.

3.1.4 Selection criteria

If you do not enter any values in the criteria edit boxes, all relevant records will be included. Alternatively, you may choose any combination of values to select data subsets. If you specify more than one field value, then all of the conditions must be met.

The reports by date are based on care date. Both 'From' and 'To' dates must be entered. Records are listed if the patients were in care between the 'From' and 'To' dates. For example, to list patients in care on 01/02/09; specify From 01/02/09 To 01/02/09. You could choose intervals longer than one day – such as a week - but only those patients in care for the entire period would be listed.

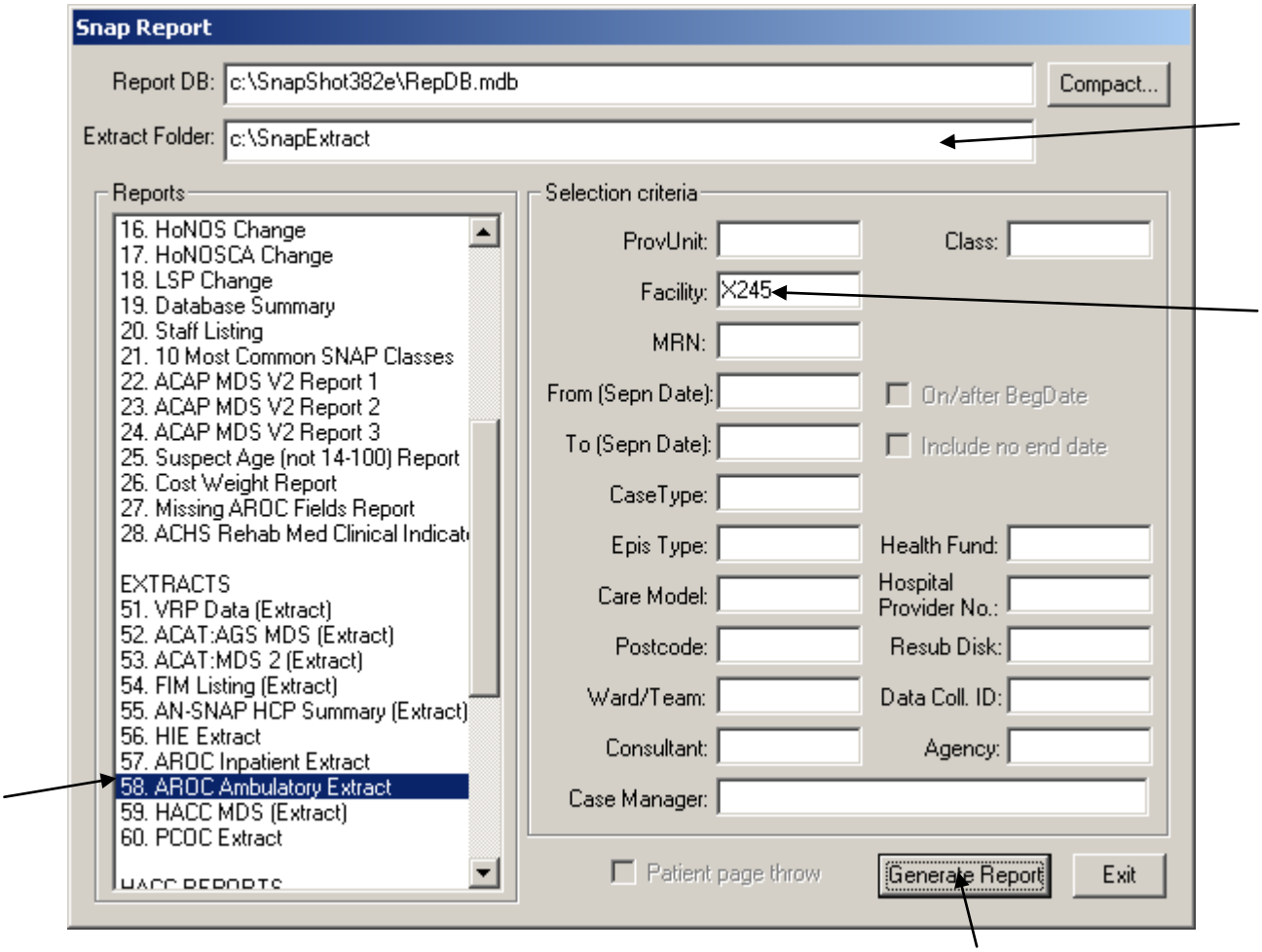
3.1.5 Generating the AROC Ambulatory Extract

This report produces a fixed format ASCII file that comprises the version 1 AROC Ambulatory Clinical data set to be submitted to AROC. To create the AROC Ambulatory Extract, press Shift-F8 whilst positioned on any of the data lists in SNAPshot. Select item 58. AROC Ambulatory Extract from the list of reports, enter your Facility Code and then press Generate Report. This produces a text file named "AROCFacilityNameYYYYMMDDV3.8x.txt" where facility-name is the name as entered in the Facility screen and YYYYMMDD is today's date (the day the extract is created). Do not change the name of the file created by SNAPshot. Please note that 'From' and 'To' dates should not be selected when creating the AROC Ambulatory Extract.

The AROC Ambulatory Extract text file is written into the extract folder. The default location of the extract folder is c:\Snapshot, however, you can specify another folder which can be on any computer including and/or other than the one on which SNAPshot is installed (for further information please refer to either the SNAPshot V3.8 Manual or to 3.1.3 above).

The file can now be uploaded to AROC via AROC Online Services (AOS) – *note that the extract contains 'client MRN' and 'date of birth', but does not include any other identifying data items*.

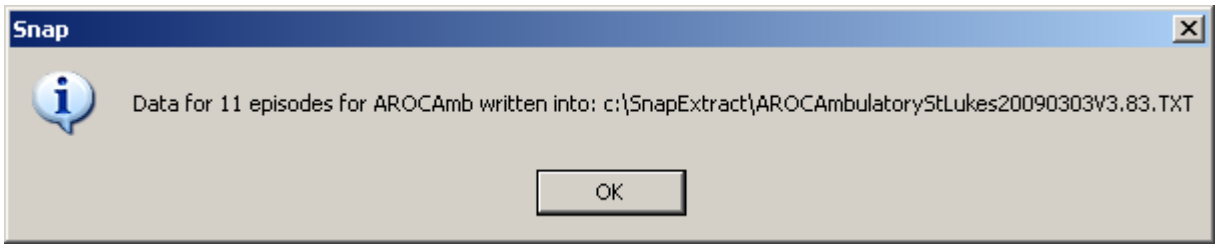
Figure 4 Extracting the AROC data



3.1.6 The Generate button

When you press the Generate button, you can see where the generated extract will be found once the command has been completed.

Figure 5 Dialogue box showing file route for data generated by the "AROC Ambulatory Extract" report



3.1.7 Uploading your AROC data extract file to AROC via AROC Online Services

Currently the AROC data extract is submitted to AROC via email to aroc@uow.edu.au.

An error check is run on all submitted data and an acknowledgment email with an audit report attached is sent to the provided email addresses.

In the future the AROC data extract will be submitted to AROC using AROC Online Services (AOS), for which you will need your facility's UserName and Password. All facilities submitting data to AROC will be informed when this functionality becomes available. The process will then be as follows.

To submit your data to AROC, log in to AOS and click the <Upload Data> button on the main menu. Click on <browse>, select the file that is your most current AROC extract, (from the c:/SnapExtract folder) then press <submit>. You will be asked to confirm the file you selected is the correct data to be submitted to AROC. AOS determines the AROC dataset version from your extract file name (this is why it is important not to change the filename given to your extract by SNAPshot). If the file selected is correct press the <Next> button to go to the Upload AROC dataset Audit screen. Check the email address listed is correct; add up to three more email addresses to also receive the acknowledgment and audit email from AROC for this data submission. Click <email audit report and submit the data> button to submit your data to the AROC database. All listed emails will receive an acknowledgment email from AROC with a data audit report as an attachment. AROC will also be sent an email. The audit email is your confirmation that AROC has received your data.

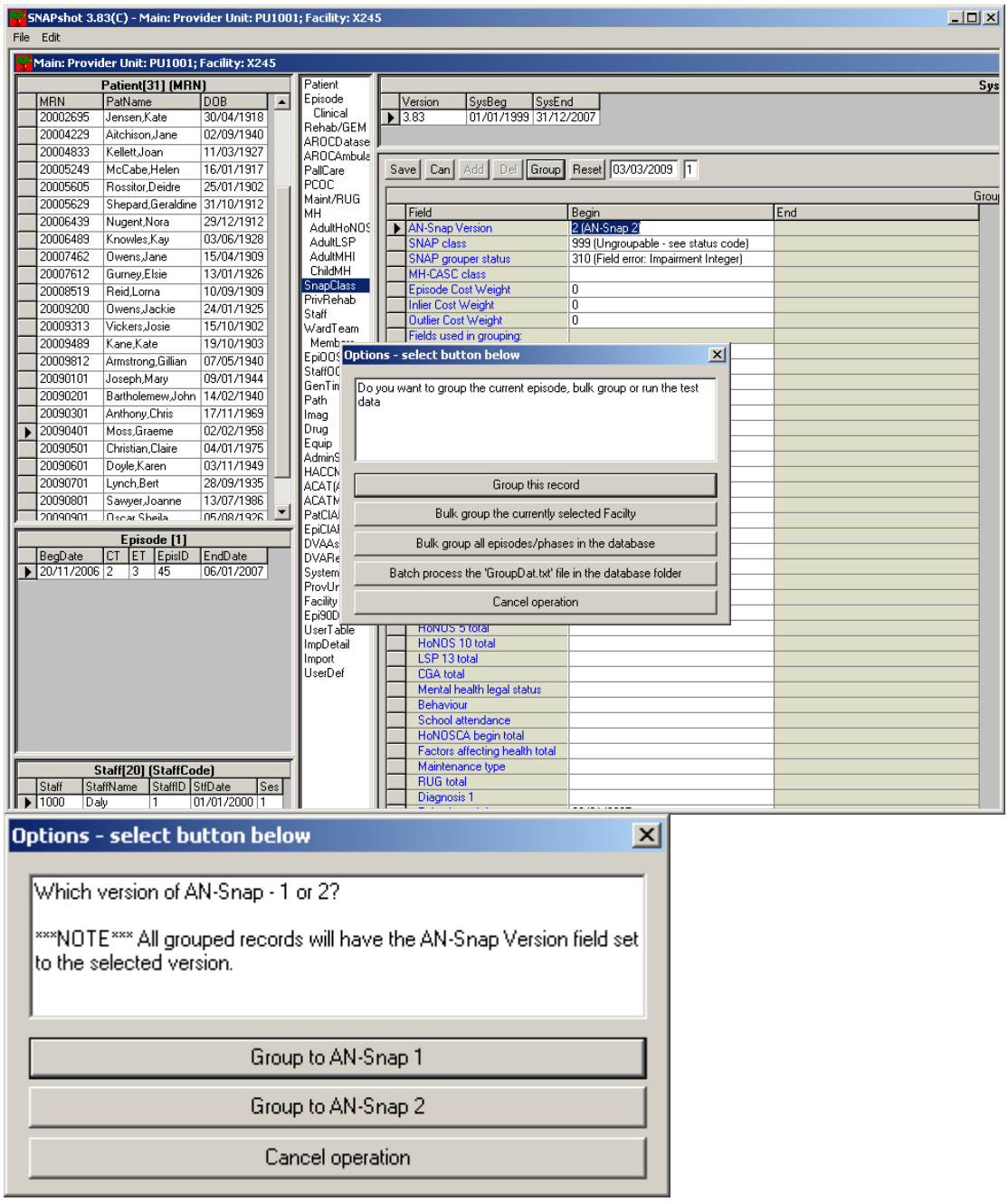
3.2 Assigning an AN-SNAP class to your episodes

If you wish to analyse your own data by AN-SNAP class you should use the inbuilt grouper tool to assign a SNAP class to each episode of care. This can be done either by selecting the SnapClass dataset and clicking on the [Group] button for each completed Episode (SNAPshot defaults to the version 2 AN-SNAP classes unless you specify within the facility screen to use version 1 AN-SNAP classes) or, by bulk grouping all episodes in the database by holding down the <shift> key and [Group], then select [Bulk group all episodes/phases in the databases]. In this case SNAPshot asks if you would like to group to Version 1 or Version 2 AN-SNAP classes.

NOTE: From July 2007 AROC will do all reporting using AN-SNAP version 2 classes.

Further information on Grouping can be found in the SNAPshot V3.8 Manual.

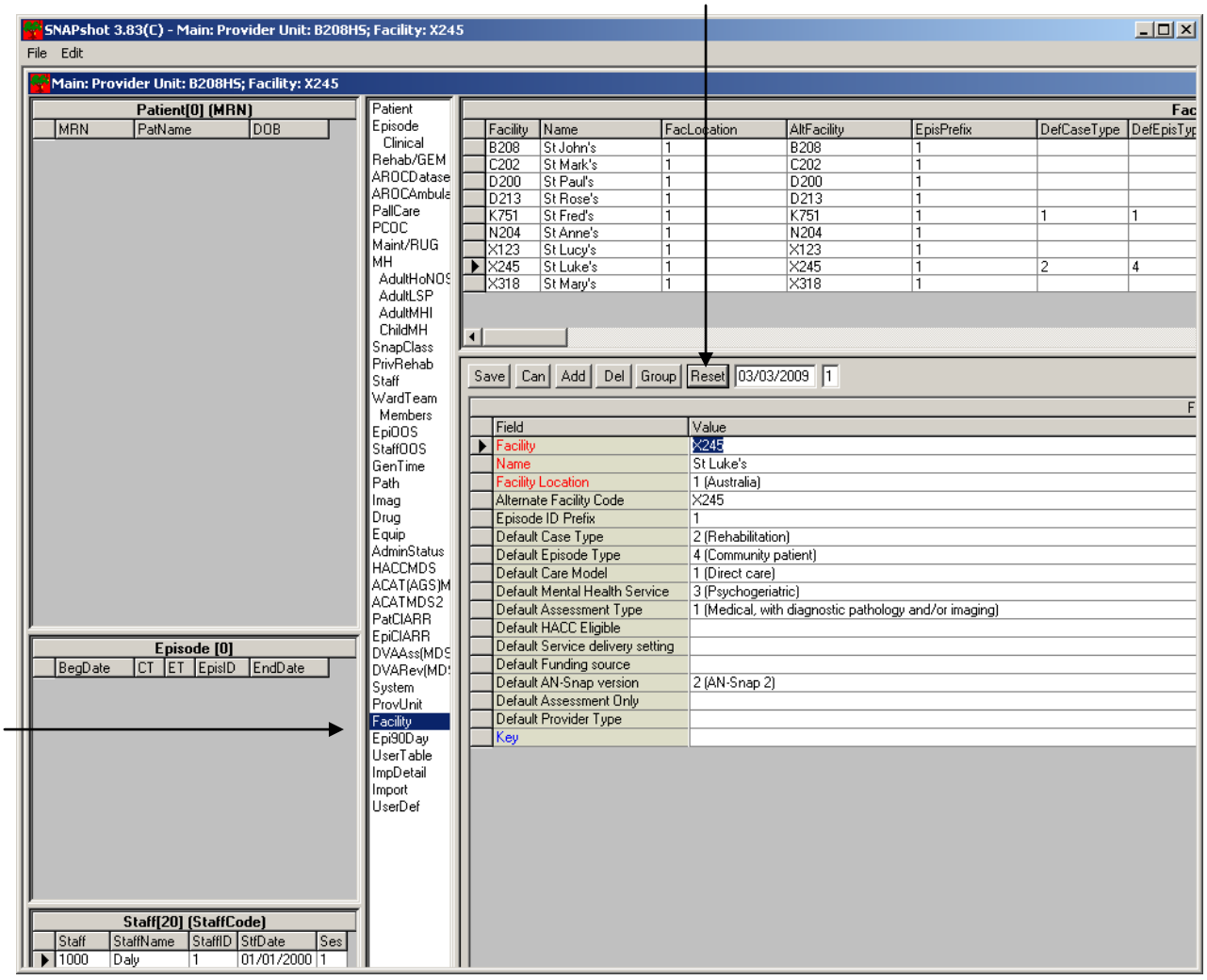
Figure 6 Bulk assigning an AN-SNAP class and the version option.


SNAPshot 3.83(C) - Main: Provider Unit: PU1001; Facility: X245
File Edit
Main: Provider Unit: PU1001; Facility: X245
Patient[31] (MRN)
Episode [1]
Staff[20] (StaffCode)
Options - select button below
Do you want to group the current episode, bulk group or run the test data
Group this record
Bulk group the currently selected Facilty
Bulk group all episodes/phases in the database
Batch process the 'GroupDat.txt' file in the database folder
Cancel operation
Options - select button below
Which version of AN-Snap - 1 or 2?
NOTE All grouped records will have the AN-Snap Version field set to the selected version.
Group to AN-Snap 1
Group to AN-Snap 2
Cancel operation

4 Troubleshooting

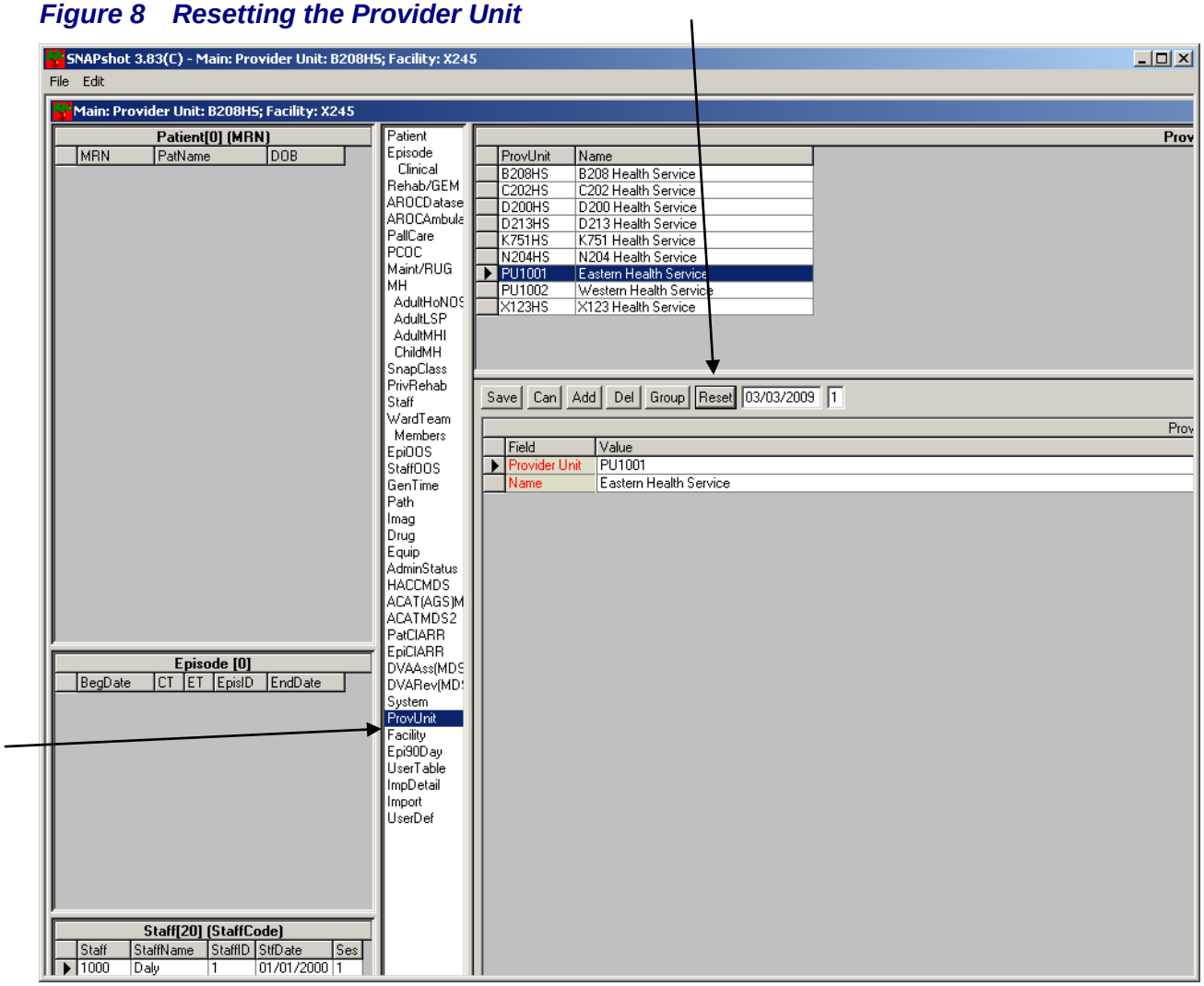
If, on opening up the main screen and logging on, you do not see any data, you will need to reset which Facility and Provider unit SNAPshot should be focusing on. To do this, simply highlight Facility in the set list and then click on Reset (this button can be found in the middle of the right hand window), refer to Figure 7, now highlight ProvUnit in the set list and click Reset again, refer to Figure 8. At this point your data should 'magically' reappear, refer to Figure 9. [If you have more than one Facility or Provider Unit you will need to also select the appropriate facility/provunit in the multi list (top right hand window)].

Figure 7 Resetting the Facility



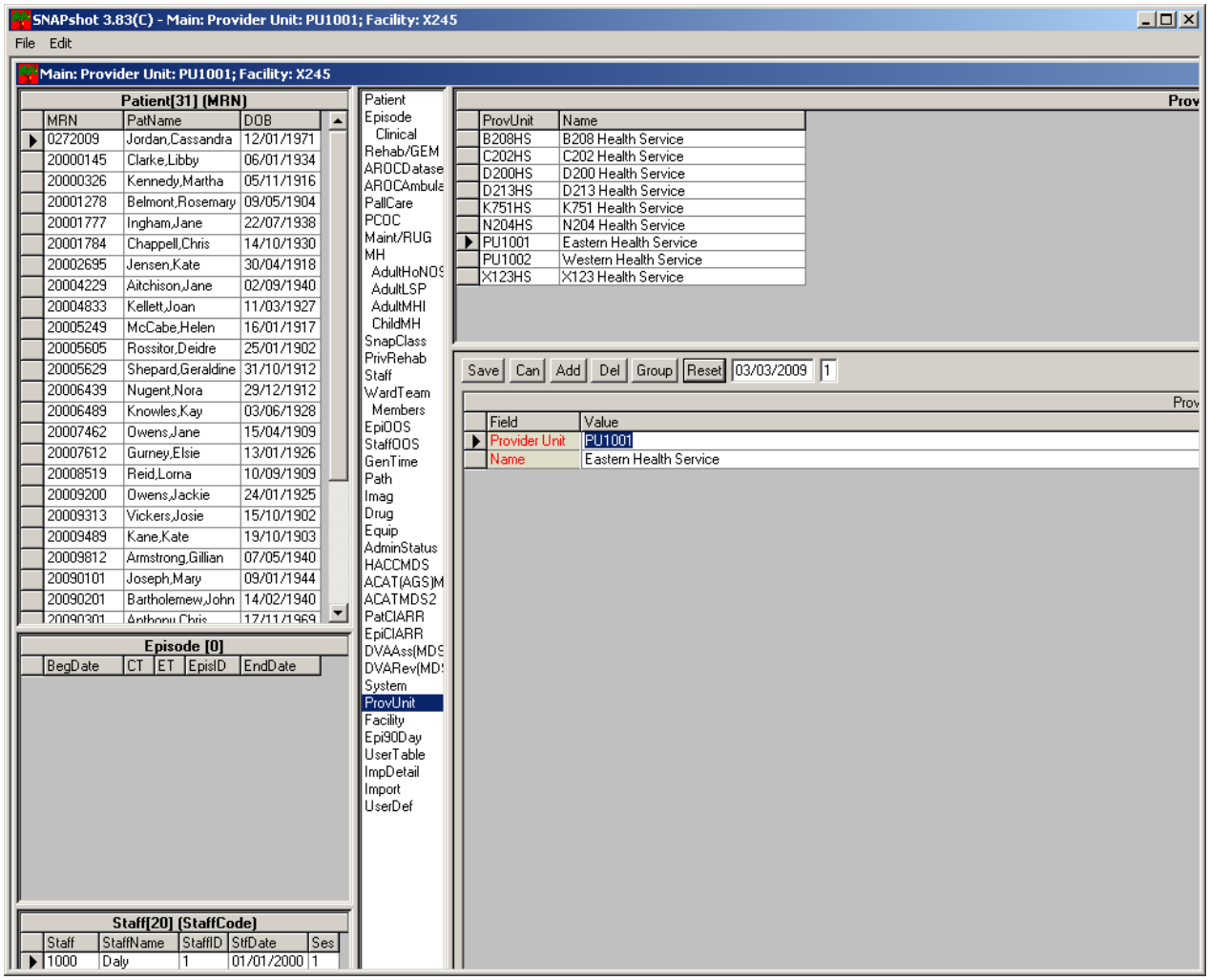
Once the Facility has been reset, the Facility wide data items will be visible.

Figure 8 Resetting the Provider Unit



Once the provider Unit has been reset the data sets under that provider unit will be visible.

Figure 9 After resetting the Facility and Provider Unit



5 SNAPclass status codes

When you attempt to assign a SNAPclass to a record, either by performing a bulk group operation, refer to 3.2 Assigning an AN-SNAP class to your episodes above, or by selecting SNAPclass in the setlist and hitting the group button for individual records, SNAPshot will assign a status code to the record. These status codes can be viewed, by record, in the SNAPclass screen, and a summary of all the ungroupable records (that is, those records with a status code other than 100) can be found in the Database Summary, report number 19.

Refer to Table 7 below to determine how best to correct the problem.

Table 7 SNAPclass status codes and suggested resolutions to field errors

Status Code	Description	Suggested resolution
100	Grouping OK	No action required
301	Field error: CaseType	Check Case Type, refer to the AN-SNAP clinical training handbook for business rules
302	Field error: EpisType	Check Episode Type, refer to the AN-SNAP clinical training handbook for business rules
303	Field error: Assessment Only	Currently, it is only possible to assign a SNAP class to Assessment Only for a Rehabilitation Episode
304	Field error: Age	Check date of birth (rules now prevent non-sensical DOBs but previous versions didn't apply any checks)
305	Field error: LOS	Episode End Date needs to completed (along with all

Status Code	Description	Suggested resolution
		supporting episode end data)
306	Field error: ProvType	Check Provider Type, refer to the AN-SNAP clinical training handbook for business rules
307	Field error: Phase	Check PallCare Phase, refer to the AN-SNAP clinical training handbook for business rules
308	Field error: Severity Total	For Ambulatory pallcare clients - check valid values for Pain, Symptom, Pysch/Spiritual,Family/carer scores within PallCare dataset
309	Field error: RUG Admission Total	Ensure that the RUG scores have been entered in the Maint/RUG screen
310	Field error: Impairment Integer	Ensure that the Impairment Code has been entered in the Rehab/GEM screen
311	Field error: FIM Admission Motor Score	Ensure that the FIM motor scores have been entered in the Rehab/GEM screen
312	Field error: FIM Admission Cognition Score	Ensure that the FIM cognition scores have been entered in the Rehab/GEM screen
313	Field error: HoNOS Total	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
314	Field error: HoNOS Overactive Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
315	Field error: HoNOS ADL Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
316	Field error: Maintenance Type	Ensure that the Maintenance Type has been entered in the Maint/RUG screen
317	Field error: Focus of Care	Ensure that the MH data items have been entered for mental health episodes
318	Field error: Sole Practitioner	Ensure that the data item Sole Practitioner in the Episode Screen has been completed
319	Field error: MH Service	Ensure that the Mental Health Service data item in the Episode screen has been completed for mental health episodes
320	Field error: Diagnosis 1	Enter primary diagnosis (diagnosis 1) in Clinical screen for mental health episodes
321	Field error: HoNOS 5 Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
322	Field error: HoNOS 10 Score	Ensure that the AdultHoNOS data items have been entered for adult mental health episodes
323	Field error: LSP 13 Score	Ensure that the AdultLSP data items have been entered for adult mental health episodes
324	Field error: CGAS Begin Score	Enter CGA begin (and end) scores in ChildMH screen for child mental health episodes
325	Field error: MHLS	Ensure that the MH data items have been entered for mental health episodes
326	Field error: HONOSCA Behaviour Score	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
327	Field error: HONOSCA School Score	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
328	Field error: HONOSCA Total Begin Score	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
329	Field error: Factors Affecting Health Status Total	Ensure that the age specific HoNOS (child / adolescent) data items have been entered
330	Field error: Complete (End Date)	Enter Episode end date and supporting episode end data
999	Can't assign class	Refer to status code above and suggested resolution

Appendix 1 Control Keys

Key	Action
Arrows	Move left, right, up or down.
Enter or Tab	Save field changes (if any) and move to the next field to the right or down.
Shift+Tab	Save field changes (if any) and move to the previous field to the left or up.
Alt+down arrow	For coded fields – open the drop down list.
Ctrl+A	Add a new record.
Ctrl+S	Save the current changes.
Esc	If the field in edit mode cancel field changes. In record edit mode, cancel record changes. If you are positioned in the EditView but are not currently editing, pressing the Esc key will move the cursor to the Date field and you can move forward to the Shift field by pressing the Tab key or back to the control buttons using Shift-Tab. Pressing the Tab key on the Shift field will move you to the EditView. If you press the Esc key on the Date field, you will jump to the SetList and you can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys.
Shift+Up/Down	(on SetList) You can move up and down the SetList without selecting a set by holding down the Shift key whilst you press the Up/Down arrow keys. When you are positioned on the required set, release the Shift key and the set will be selected.
F6	The F6 key will move you forwards from segment to segment. Shift-F6 will move backwards.
F7	F7 is the 'Process' key and, for certain segments/data sets, provides additional processing options.

Appendix 2 Searching for a client by name or by mrn

You can search for a client in the 'Patient list' by surname or by Medical Record Number (MRN).

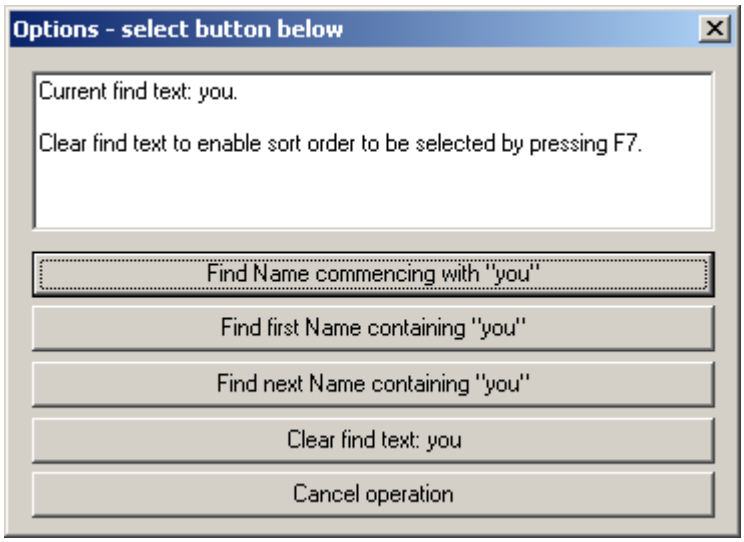
- Click in the 'Patient List' (or press the F6 key to move the cursor to it).

  If the patient list ordering is by Name, then [Name] will appear in the caption bar. If the patient list ordering is by MRN, then [MRN] will appear in the caption bar.

  It is also possible to order and search by HACC statistical key [HACCKey], however this is not relevant to the AROC data collection.
- Press the F7 key to reorder the list of clients by MRN or Name as preferred.
- To search by Name, order the patient list by name.

  Type the family name (the whole name or the first few letters). The letters you type will appear immediately to the right of the [name] in the caption bar. Press the F7 key. Choose from the "Options" Window in Figure 10.

Figure 10 Searching for a client record


Options - select button below
Current find text: you.
Clear find text to enable sort order to be selected by pressing F7.
Find Name commencing with "you"
Find first Name containing "you"
Find next Name containing "you"
Clear find text: you
Cancel operation

Alternatively, press Shift+F7 at the same time. Snapshot will automatically search for the first record that matches your selection. If the first record found is not the required one, press F7 and choose the option "Find next Name containing…".

- To search by MRN, type the required MRN and follow the same procedure as for searching by Name.

Appendix 3 AROC Impairment Codes

AUS Version 1

1 STROKE

- 1.1 Left Body Involvement (Right Brain)
- 1.2 Right Body Involvement (Left Brain)
- 1.3 Bilateral Involvement
- 1.4 No Paresis
- 1.9 Other stroke

2 BRAIN DYSFUNCTION

Non-traumatic brain dysfunction:

- 2.11 Sub-arachnoid haemorrhage
- 2.12 Anoxic brain damage
- 2.13 Other non-traumatic brain dysfunction

Traumatic brain dysfunction:

- 2.21 Open Injury
- 2.22 Closed Injury

3 NEUROLOGICAL CONDITIONS

- 3.1 Multiple Sclerosis
- 3.2 Parkinsonism
- 3.3 Polyneuropathy
- 3.4 Guillian-Barre Syndrome
- 3.5 Cerebral Palsy
- 3.8 Neuromuscular Disorders (include motor neurone disease)
- 3.9 Other neurologic disorders

4 SPINAL CORD DYSFUNCTION

Non-Traumatic Spinal Cord Dysfunction:

- 4.111 Paraplegia, Incomplete
- 4.112 Paraplegia, Complete
- 4.1211 Quadriplegia Incomplete C1-4
- 4.1212 Quadriplegia Incomplete C5-8
- 4.1221 Quadriplegia Complete C1-4
- 4.1222 Quadriplegia Complete C5-8
- 4.13 Other non-traumatic SCI

Traumatic Spinal Cord Dysfunction:

- 4.211 Paraplegia, Incomplete
- 4.212 Paraplegia, Complete
- 4.2211 Quadriplegia Incomplete C1-4
- 4.2212 Quadriplegia Incomplete C5-8
- 4.2221 Quadriplegia Complete C1-4
- 4.2222 Quadriplegia Complete C5-8
- 4.23 Other traumatic spinal cord dysfunction

5 AMPUTATION OF LIMB

- 5.1 Single Upper Amputation Above the Elbow
- 5.2 Single Upper Amputation Below the Elbow
- 5.3 Single Lower Amputation Above the Knee (includes through knee)
- 5.4 Single Lower Amputation Below the Knee
- 5.5 Double Lower Amputation Above the Knee (includes through knee)
- 5.6 Double Lower Amputation Above/below the Knee

5.7 Double Lower Amputation Below the Knee
5.8 Partial Foot Amputation (includes single/double)
5.9 Other Amputation

6 ARTHRITIS

6.1 Rheumatoid Arthritis
6.2 Osteoarthritis
6.9 Other Arthritis

7 PAIN SYNDROMES

7.1 Neck Pain
7.2 Back Pain
7.3 Extremity Pain
7.4 Headache (includes migraine)
7.5 Multi-site pain
7.9 Other Pain (includes abdominal/chest wall)

8 ORTHOPAEDIC CONDITIONS

Fracture: *(includes dislocation, excludes neurological involvement)*

8.111 Fracture of hip, unilateral (includes #NOF)
8.112 Fracture of hip, bilateral (includes #NOF)
8.12 Fracture of shaft of femur (excludes femur involving knee joint)
8.13 Fracture of pelvis
8.141 Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
8.142 Fracture of lower leg, ankle, foot
8.15 Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
8.16 Fracture of spine (excludes where the major disorder is pain)
8.17 Fracture of multiple sites (multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum. Excludes with brain injury or with spinal cord injury)
8.19 Other orthopaedic fracture (includes jaw, face, rib, orbit or sites not elsewhere classified)

Post Orthopaedic Surgery: *(includes secondary to fracture or arthritis)*

8.211 Unilateral hip replacement
8.212 Bilateral hip replacement
8.221 Unilateral knee replacement
8.222 Bilateral knee replacement
8.231 Knee and hip replacement same side
8.232 Knee and hip replacement differrent sides
8.24 Shoulder replacement or repair
8.25 Post spinal surgery (includes nerve root injury (laminectomy, spinal fusion, discectomy; excludes spinal cord injury or caudaequina)
8.26 Other orthopaedic surgery

9 CARDIAC

9.1 Following recent onset of new cardiac impairment (AMI, heart transplant, cardiac surgery)
9.2 Chronic cardiac insufficiency
9.3 Heart and heart/lung transplant

10 PULMONARY

10.1 Chronic Obstructive Pulmonary Disease
10.2 Lung Transplant
10.9 Other Pulmonary

11 BURNS

11 Burns

12 CONGENITAL DEFORMITIES

- 12.1 Spina Bifida
- 12.9 Other Congenital

13 OTHER DISABLING IMPAIRMENTS

- 13.1 Lymphoedema
- 13.2 Other Disabling Impairments - cases that cannot be classified into a specific group. This classification should rarely be used.

14 MAJOR MULTIPLE TRAUMA (excludes multiple fractures only)

- 14.1 Brain + Spinal Cord Injury
- 14.2 Brain + Multiple Fracture/Amputation
- 14.3 Spinal Cord + Multiple Fracture/ Amputation
- 14.9 Other Multiple Trauma

15 DEVELOPMENTAL DISABILITIES (excludes cerebral palsy, includes patients who have significant intellectual disabilities)

- 15.1 Developmental Disabilities

16 RE-CONDITIONING/ RESTORATIVE (excludes primary cardiac insufficiency or primary pulmonary insufficiency)

- 16.1 Re-conditioning following surgery
- 16.2 Re-conditioning following medical illness
- 16.3 Cancer rehab (where patient is de-conditioned as a result of their cancer or treatment for their cancer; excludes patients with ongoing cancer management issues)

Appendix 4 List of Health Funds and Other Payers

Health Fund Code	Health Fund
1	ACA Health Benefits Fund
2	The Doctor's Health Fund Ltd
11	Australian Health Management Group
13	Australian Unity Health Limited
14	BUPA Australia Health Pty Ltd (trading as HBA in Vic & Mutual Community in SA)
18	CBHS Health Fund Limited
19	Cessnock District Health Benefits Fund
20	Credicare Health Fund Limited
22	Defence Health Limited
25	Druids Friendly Society - Victoria
26	Druids Friendly Society - NSW
29	Geelong Medical and Hospital Benefits Assoc Ltd (GMHBA)
32	Grand United Corporate Health Limited
37	Health Care Insurance Limited
38	Health Insurance Fund of W.A.
40	Healthguard Health Benefits Fund Ltd (trading as Central West Health, CY Health, & GMF Health)
41	Health-Partners
46	Latrobe Health Services Inc.
47	Lysaght Peoplecare Ltd
48	Manchester Unity Australia Ltd
49	MBF Australia Ltd
50	Medibank Private Ltd
53	Mildura District Hospital Fund Limited
56	Naval Health Ltd
57	NIB Health Funds Ltd
61	Phoenix Health Fund Ltd
65	Queensland Country Health Ltd
66	Railway & Transport Health Fund Ltd
68	Reserve Bank Health Society Ltd
71	St Luke's Medical & Hospital Benefits Association Ltd
74	Teachers Federation Health Ltd
77	HBF Health Funds Inc
78	HCF - Hospitals Contribution Fund of Australia Ltd, The
81	Transport Health Pty Ltd
83	Westfund Ltd
85	NRMA Health (MBF Alliances)
86	Queensland Teachers' Union Health Fund Ltd
87	Police Health
999	Unknown

CTP Code	CTP Insurer
601	Allianz Australia Insurance Ltd
602	Australian Associated Motor Insurers Ltd
603	QBE Insurance (Australia)
604	Suncorp/Metway
605	RACQ Insurance Ltd
606	NRMA Insurance Ltd
607	Transport Accident Commission Vic
608	AAMI

609	CIC
610	GIO
611	QBE
612	Zurich
613	Insurance Commission of Western Australia
614	Motor Accident Insurance Board Tasmania
615	Territory Insurance Office NT
616	SGIC General Insurance
999	Unknown

WC Code	Workers Compensation Insurer
401	WorkCover Qld
402	Allianz Australia Workers Compensation
403	Cambridge Integrated Services Vic Pty Ltd
404	CGU Workers Compensation
405	JLT Workers Compensation Services Pty Ltd
406	QBE Worker's Compensation
407	Wyatt Gallagher Bassett Workers Compensation Victoria Pty Ltd
408	Employers' Mutual Indemnity
409	GIO Workers Compensation (NSW)
410	Royal & Sun Alliance Workers Compensation
411	CATHOLIC CHURCH INSURANCES LTD
412	GUILD INSURANCE LTD
413	INSURANCE COMMISSION OF WA
414	Zurich Australia Insurance Ltd
415	WESFARMERS FEDERATION INSURANCE LTD
416	Territory Insurance Office
417	ComCare
418	Victoria Workcover Authority
999	Unknown

Appendix 5 Employment Status Inclusions/ Exclusions by code

CODE 1 Employed:

Persons aged 15 years and over who, during the reference week:

(a) worked for one hour or more for pay, profit, commission or payment in kind in a job or business, or on a farm (comprising 'Employees', 'Employers' and 'Own Account Workers'); or
(b) worked for one hour or more without pay in a family business or on a farm (i.e. 'Contributing Family Worker'); or
(c) were 'Employees' who had a job but were not at work and were:

- on paid leave
- on leave without pay, for less than four weeks, up to the end of the reference week
- stood down without pay because of bad weather or plant breakdown at their place of employment, for less than four weeks up to the end of the reference week
- on strike or locked out
- on workers' compensation and expected to be returning to their job, or
- receiving wages or salary while undertaking full-time study; or

(d) were 'Employers', 'Own Account Workers' or 'Contributing Family Workers' who had a job, business or farm, but were not at work.

CODE 2 Unemployed:

Unemployed persons are those aged 15 years and over who were not employed during the reference week, and:
(a) had actively looked for full-time or part-time work at any time in the four weeks up to the end of the reference week. Were available for work in the reference week, or would have been available except for temporary illness (i.e. lasting for less than four weeks to the end of the reference week). Or were waiting to start a new job within four weeks from the end of the reference week and would have started in the reference week if the job had been available then; or
(b) were waiting to be called back to a full-time or part-time job from which they had been stood down without pay for less than four weeks up to the end of the reference week (including the whole of the reference week) for reasons other than bad weather or plant breakdown. Note: Actively looking for work includes writing, telephoning or applying in person to an employer for work. It also includes answering a newspaper advertisement for a job, checking factory or job placement agency notice boards, being registered with a job placement agency, checking or registering with any other employment agency, advertising or tendering for work or contacting friends or relatives.

CODE 3 Not in the Labour Force:

Persons not in the labour force are those persons aged 15 years and over who, during the reference week, were not in the categories employed or unemployed, as defined. They include persons who were keeping house (unpaid), retired, voluntarily inactive, permanently unable to work, persons in institutions (hospitals, gaols, sanatoriums, etc.), trainee teachers, members of contemplative religious orders, and persons whose only activity during the reference week was jury service or unpaid voluntary work for a charitable organisation.

Appendix 6 AROC Impairment Coding Guidelines

The aim of these guidelines is to assist in correctly classifying a rehabilitation episode according to impairment groups. There are 2 over-riding rules that need to be considered when using these guidelines:

1. The episode should be classified according to the **primary** reason for the **current** episode of rehabilitation care

2. Rehabilitation program names related to funding are not necessarily the same as the impairment group names
   (eg. a patient in a debility/reconditioning funding program may be having rehabilitation due to deconditioning related to a cardiac disorder – this episode should be classified to 9.2 Chronic cardiac insufficiency not to 16 Re-conditioning/restorative

Please note that the examples of aetiologic diagnoses that underpin each impairment, which are provided under each impairment group, are not exhaustive.

(1) STROKE

USE this group for cases with the diagnosis of cerebral ischemia due to vascular thrombosis, embolism, or haemorrhage.

Do NOT use this group for:
1. cases of brain dysfunction secondary to non-vascular causes such as trauma, inflammation, tumour or degenerative changes.
2. cases of subarachnoid haemorrhage. These should be classified to BRAIN DYSFUNCTION (2)

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
STROKE	1.1 Left Body Involvement (Right Brain) 1.2 Right Body Involvement (Left Brain) 1.3 Bilateral Involvement 1.4 No Paresis 1.9 Other Stroke	Intracerebral haemorrhage
		Other and unspecified intracranial haemorrhage
		Occlusion and stenosis of precerebral arteries, with cerebral infarction
		Occlusion of cerebral arteries, with cerebral infarction
		Acute, but ill-defined cerebrovascular disease
		Late effects of cerebrovascular disease

(2) BRAIN DYSFUNCTION

Non–traumatic Brain Dysfunction

USE this group cases with such aetiologies as neoplasm including metastases, encephalitis, inflammation, anoxia, metabolic toxicity, or degenerative processes.

Do NOT use this group for cases with hemorrhagic stroke (other than subarachnoid haemorrhage) - These should be classified to STROKE (1).

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
BRAIN DYSFUNCTION	2.11 Non-traumatic subarachnoid haemorrhage	Non-traumatic spontaneous/ berry aneurysm
	2.12 Anoxic brain damage	Anoxic brain damage(Anoxic/ hypoxic encephalopathy)
	2.13 Other non-traumatic brain dysfunction	Encephalitis
		Meningitis
		Neoplasm/tumour of brain or meninges – malignant or benign (includes secondary tumours)
		Neoplasm/tumour of cranial nerves
		Intracranial abscess
		Hydrocephalus
		Toxic encephalopathy

Traumatic Brain Dysfunction

USE this group for cases with motor and/or cognitive disorder secondary to brain trauma.

Definition: A closed head injury is defined as an injury where the meninges remain intact (includes a linear fracture of the skull)

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
BRAIN DYSFUNCTION	2.21 Traumatic, open injury	Skull fracture
		Cerebral laceration and contusion, with open intracranial wound
		Subarachnoid, subdural, extradural, and other unspecified haemorrhage following injury
		Other and unspecified intracranial haemorrhage following injury
BRAIN DYSFUNCTION	2.22 Traumatic, closed injury	Linear skull fracture
		Concussion
		Cerebral laceration and contusion
		Subarachnoid, subdural, extradural and other unspecified haemorrhage following injury
		Other and unspecified intracranial haemorrhage following injury

(3) NEUROLOGIC CONDITIONS

USE this group for cases with neurologic or neuromuscular dysfunctions of various aetiologies.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
NEUROLOGIC CONDITIONS	3.1 Multiple Sclerosis	Multiple Sclerosis
	3.2 Parkinsonism	Parkinsonism
	3.3 Polyneuropathy	Hereditary and idiopathic peripheral neuropathy Peripheral neuropathy, inflammatory, toxic, traumatic, or other Brachial plexus or lumbosacral plexus injury
	3.4 Guillain-Barré Syndrome	Acute inflammatory polyneuritis
	3.5 Cerebral Palsy	Infantile cerebral palsy
	3.8 Neuromuscular Disorders	Post poliomyelitis/ post polio syndrome
		Motor neurone disease
		Myasthenia gravis
		Muscular dystrophies and other myopathies
	3.9 Other Neurologic disorders	Other extrapyramidal disease and abnormal movement disorders
		Spinocerebellar disease
		Disorders of the autonomic nervous system
		Other demyelinating diseases of the central nervous system

(4) SPINAL CORD DYSFUNCTION

USE this group only if there is a spinal cord/ caudaequina dysfunction.

Do NOT use this group for post spinal surgery, unless the surgery has resulted in dysfunction of the spinal cord/ caudaequina.

Non-traumatic Spinal Cord Dysfunction

USE this group for cases with quadriplegia/paresis and paraplegia/paresis of non-traumatic (i.e., **medical or post-operative**) origin.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
SPINAL CORD DYSFUNCTION	4.111 Paraplegia, Incomplete 4.112 Paraplegia, Complete 4.1211 Quadriplegia, Incomplete, C1-4 4.1212 Quadriplegia, Incomplete, C5-8 4.1221 Quadriplegia, Complete, C1-4 4.1222 Quadriplegia, Complete, C5-8 4.13 Other Non-traumatic Spinal Cord Dysfunction	Tuberculosis/ infective processes involving the vertebral column
		Neoplasm/ tumour of spinal column or spinal meninges, malignant or benign (includes secondary tumours)
		Neoplasm of other parts of nervous system, of unspecified nature
		Transverse myelitis
		Intraspinal or paraspinal abscess
		Dissection of aorta
		Aortic aneurysm, ruptured
		Spontaneous haematoma
		Spondylosis with myelopathy
		Spinal infarction
		Intervertebral disc disorder with myelopathy
		Spinal stenosis in cervical region (if deficits include weakness)
		Spinal stenosis, other than cervical (if deficit includes weakness)
		Late effects of spinal cord injury
		Pathological fracture with associated spinal cord dysfunction
		An unavoidable/recognised surgical complication resulting in spinal cord dysfunction following surgery for the above conditions

Traumatic Spinal Cord Dysfunction

USE this group for cases with quadriplegia/paresis and paraplegia/paresis secondary to trauma (accident/injury).

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
SPINAL CORD DYSFUNCTION	4.211 Paraplegia, Incomplete 4.212 Paraplegia,	Fracture of vertebral column with spinal cord injury
		Spinal cord injury without evidence of spinal bone injury

	Complete 4.2211 Quadriplegia, Incomplete, C1-4 4.2212 Quadriplegia, Incomplete, C5-8 4.2221 Quadriplegia, Complete, C1-4 4.2222 Quadriplegia, Complete, C5-8 4.23 Other Traumatic Spinal Cord Dysfunction	Spinal cord dysfunction resulting from surgical misadventure

(5) AMPUTATION OF LIMB

USE this group for cases in which the major deficit is partial or complete absence of a limb.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
AMPUTATION OF LIMB	5.1 Single Upper Amputation Above the Elbow 5.2 Single Upper Amputation Below the Elbow 5.3 Single Lower Amputation Above the Knee (includes through the knee) 5.4 Single Lower Amputation Below the Knee 5.5 Double Lower Amputation Above the Knee (includes through the knee) 5.6 Double Lower Amputation Above/Below the Knee	Neoplasm of bones or cartilage and other soft tissue of limb Secondary neoplasm of bone Diabetes with neurologic manifestations or diabetes with peripheral circulatory disorders Hereditary and idiopathic peripheral neuropathy Inflammatory and toxic neuropathy Atherosclerosis of the extremities Peripheral vascular disease, unspecified Arterial embolism and thrombosis, extremities Buerger's disease Acquired deformity or injury affecting limbs Aneurysm of extremities Traumatic amputation (complete) (partial) Amputation stump complication/ revision Haemangioma Vasculitis (eg scleroderma, SLE) Connective tissue disorders Gangrene Infective processes (eg osteomyelitis/ cellulitis)

	5.7 Double Lower Amputation Below the Knee 5.8 Partial Foot Amputation (includes single/double) 5.9 Other Amputation	Congential limb loss (when prosthesis required)

(6) ARTHRITIS

USE this group for cases in which the major disorder is arthritis of all aetiologies.

Do NOT use for cases entering rehabilitation immediately after joint replacement, even if the procedure was performed secondary to arthritis. These should be classified to POST ORTHOPAEDIC SURGERY (8.211 – 08.26)

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
ARTHRITIS	6.1 Rheumatoid arthritis	Rheumatoid arthritis
		Juvenile chronic polyarthritis
		Chronic post-rheumatic arthropathy
	6.2 Osteoarthritis	Osteoarthritis and allied disorders
	6.9 Other Arthritis	Psoriatic arthropathy
		Scleroderma
		Systemic lupus erythematosus
		Systemic sclerosis
		Dermatomyositis
		Polymyositis
		Pyogenic arthritis
		Other and unspecified arthropathies
		Fibromyalgia
		Ankylosing spondylitis

(7) CHRONIC PAIN

USE this group for cases in which the primary purpose for this rehabilitation episode is pain management.

Do NOT use this group if pain management is only one component of the patient's rehabilitation program. These should be classified to the group representing the primary impairment.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
PAIN SYNDROMES	7.1 Neck Pain 7.2 Back Pain 7.3 Extremity Pain 7.4 Headache (includes migraine) 7.5 Multi-site pain 7.9 Other Pain (includes abdominal/chest wall)	Various aetiologies

(8) ORTHOPAEDIC DISORDERS

USE this group for cases in which the major disorder is post-fracture of bone or post-arthroplasty (joint replacement).

Fracture *(includes dislocation)*

USE when joint replacement (arthroplasty or hemiarthroplasty) is part of the fracture treatment (eg if rehabilitation follows a hip replacement for hip fracture)

AROC Impairment Group	AROC Impairment Group Code	
FRACTURE	8.111 Fracture of Hip, unilateral	includes #NOF
	8.112 Fracture of Hip, bilateral	includes #NOF
	8.12 Fracture of shaft of femur	excludes femur involving knee joint
	8.13 Fracture of pelvis	
	8.141 Fracture of knee	includes patella, femur involving knee joint, tibia or fibula involving knee joint
	8.142 Fracture of lower leg, ankle, foot	
	8.15 Fracture of upper limb	includes hand, fingers, wrist, forearm, arm, shoulder
	8.16 Fracture of spine	excludes where the major disorder is pain
	8.17 Fracture of multiple sites	multiple bones of same lower limb, both lower limbs, lower with upper limb, lower limb with rib or sternum. Excludes with brain injury (classify to 14.2) or with spinal cord injury (classify to 14.3)
	8.19 Other orthopaedic fracture	includes jaw, face, rib, orbit or sites not elsewhere classified

Post Orthopaedic Surgery

USE this group for cases where the orthopaedic surgery involved the revision or repair of previous orthopaedic surgery.
Do NOT use this group when orthopaedic surgery is part of acute fracture management. These should be classified to 8.111 – 8.19.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
POST ORTHOPAEDIC SURGERY	8.211 Unilateral hip replacement 8.212 Bilateral hip replacement 8.221 Unilateral knee replacement 8.222 Bilateral knee replacement	Psoriatic arthropathy
		Pyogenic arthritis
		Rheumatoid arthritis
		Juvenile chronic polyarthritis
		Chronic post-rheumatic arthropathy
		Osteoarthritis and allied disorder
		Other and unspecified arthropathies
		Ankylosing spondylitis
		Mechanical complication of internal orthopedic device, implant and graft

	8.231 Knee and hip replacement same side 8.232 Knee and hip replacement different sides 8.24 Shoulder replacement or repair	Infection and inflammatory reaction due to internal orthopedic device, implant and graft
		Other complications due to internal orthopedic or prosthetic device, implant and graft
		Neoplasm of bone and articular cartilage
		Secondary neoplasm of bone
	8.25 Post spinal surgery	Includes nerve root injury (laminectomy, spinal fusion, discectomy) Includes spinal deformity surgery Excludes spinal cord, caudaequina/major nerve root dysfunction (classify to 4)
	8.26 Other orthopaedic surgery	Other and unspecified disorders of joint
		Pathologic fracture requiring surgical intervention
		Osteotomy
		Bone Lengthening

(9) CARDIAC

USE for cases in which the purpose of this rehabilitation episode is to address poor activity tolerance secondary to cardiac insufficiency or general deconditioning due to cardiac disorder.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
CARDIAC DISORDERS	9.1 Cardiac disorder following recent onset of new cardiac impairment	Acute myocardial infarction
		Cardiac myopathy
		Post cardiac surgery
	9.2 Chronic cardiac insufficiency	Coronary atherosclerosis Ischemic heart disease Heart failure Cardiac myopath
	9.3 Heart or heart/lung transplant	

(10) PULMONARY DISORDERS

USE for cases in which the purpose of this rehabilitation episode is to address poor activity tolerance secondary to pulmonary insufficiency.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
PULMONARY DISORDERS	10.1 Chronic Obstructive Pulmonary Disease	Chronic obstructive pulmonary disease
	10.2 Lung Transplant	
	10.9 Other Pulmonary Disorders	Chronic bronchitis Post pneumonia Emphysema Asthma Bronchiectasis Pulmonary insufficiency following trauma, surgery

(11) BURNS

USE for cases in which the purpose of this rehabilitation episode is to address burns to major areas of skin and/or underlying tissue.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
BURNS	11 Burns	

(12) CONGENITAL DEFORMITIES

USE for cases in which the purpose of this rehabilitation episode is to address an anomaly or deformity of the nervous or musculoskeletal system that has been present since birth.

12.1 Spina Bifida
12.9 Other Congenital Deformities

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
CONGENITAL DEFORMITIES	12.1 Spina Bifida	Spina Bifida
	12.9 Other congenital deformities	Arthrogryposis
		Other congenital anomalies of nervous system
		Osteogenesis imperfecta

(13) OTHER DISABLING IMPAIRMENTS

USE 13.1 for cases in which the major disorder is lymphoedema.

USE 13.2 for cases that cannot be classified into any other impairment group. This group should be rarely used.

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
OTHER DISABLING IMPAIRMENTS	13.1 Lymphoedema	
	13.2 Other Disabling Impairments	This group should be rarely used.

(14) MAJOR MULTIPLE TRAUMA

USE for trauma cases with complex management due to involvement of **multiple systems or sites**, where specialised rehabilitation is required for each of the impairments.

Do NOT use for multiple fractures. These should be classified to FRACTURE OF MULTIPLE SITES (8.17).

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
MAJOR MULTIPLE TRAUMA	14.1 Brain + Spinal Cord Injury (spinal cord/ caudaequina/ spinal nerve root (major plexus or multiple roots))	
	14.2 Brain + Multiple Fracture/Amputation	
	14.3 Spinal Cord (spinal cord/ caudaequina/ spinal nerve root (major plexus or multiple roots)) + Multiple Fracture/Amputation	
	14.9 Other Multiple Trauma	

(15) DEVELOPMENTAL DISABILITY

USE for patients who have significant intellectual disabilities/ mental retardation.

Do NOT use for cases of cerebral palsy. These should be classified to CEREBRAL PALSY (3.5)

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
DEVELOPMENTAL DISABILITY	15.1 Developmental Disability	

(16) RE-CONDITIONING/ RESTORATIVE

USE for cases with generalized deconditioning not attributable to any of the other Impairment Groups (eg. where deconditioning is due to a cardiac disorder classify as 9.2; where deconditioning is due to pulmonary insufficiency classify as 10.2)

AROC Impairment Group	AROC Impairment Group Code	Aetiologic Diagnosis
RECONDITIONING/ RESTORATIVE	16.1 Re-conditioning/ restorative following surgery	Muscular wasting and disuse atrophy, not elsewhere classified
		Unspecified disorder of muscle, ligament and fascia
	16.2 Re-conditioning/ restorative following medical illness	Chronic fatigue syndrome
		Other malaise and fatigue
	16.3 Cancer rehabilitation	Deconditioning as a result of cancer or treatment for cancer.